Source: HIV disease management. Huntsville (TX): University of Texas Medical Branch Correctional Managed Care; 2002 Jul.

HIV DISEASE MANAGEMENT

1

Initial evaluation of HIV+ patients:
1) Obtain medical history including sexual history, social history, medication history, & history of opportunistic infections.
2) Complete physical examination: vitals, weight, general exam, neurologic examination, and pelvic exam with PAP and GC/chlamydia cultures. Perform pelvic exam every 6 months for HIV+ female patients.
3) Obtain baseline laboratories: CBC with differential, chemistry, LFTs, lipid profile, chronic hepatitis serology (HBV & HCV), RPR, urinalysis, CMV & toxoplasmosis titers, CD4 count (perform confirmation 2-3 weeks after baseline), HIV RNA viral load, CXR, PPD skin test, varicella-zoster titers.
4) Classify patient according to the 1993 CDC Revised Classification System for HIV Infection & record on the Master Problem List and PULHES and periodically thereafter as conditions change. Classification should be based upon the patient's lowest CD4 count (see box A, page 3).
5) Update vaccines: influenza vaccine annually, pneumoccocal vaccine with single revaccination 5 years after the first dose, and hepatitis B vaccine if not already immune.
6) Initiate prophylactic medication(s) for opportunistic infection(s) as indicated in box B page 3 & box C page 4.

2

Follow-up for HIV+ Patients:
1) Evaluate in chronic care clinic at least every 6 months.
2) Refer patients with CD4 counts < 500 cells/mm^3 to Infectious Disease Specialist/Clinic or designated physician (Texas Tech Units) for evaluation (may be done by telemedicine/DMS). Expedited referrals should be obtained for patients that are symptomatic or have AIDS (if meets criteria in Box #3). If patient refuses, contact an Infectious Disease Specialist or designated physician (Texas Tech Units) for drug therapy and ITP recommendations
3) Refer patients with CD4 count < 100 cells/mm^3 to Infectious Disease Ophthalmologist/Clinic for a retinal examination to rule out HIV retinopathy & CMV retinitis.
4) Laboratories: HIV RNA viral load & CD4 count every 3-4 months; LFTs, lipid profile, CBC with differential, & urinalysis yearly.
5) Consider discontinuing prophylactic medication(s) for opportunistic infection(s) as indicated in box B&C, page 3-4.

3

Is RT-PCR viral load > 55,000
or
CD4 count < 350
or
patient symptomatic
(CDC clinical category B & C box A, page 3)?

Yes

No

4

Do not begin therapy:
1) Monitor patient, RTC at least every 6 months,
2) Obtain CD4 count & viral load q 3-4 months. If CD4 count declines or viral load increases, repeat tests in 2 weeks (significant if CD4 count decreases > 30% or viral load increases ≥3 fold & is not due to intercurrent infection, vaccination, etc).
3) Go to box #3 when patient parameters change.

5

Consider drug therapy:
1) Discuss pros & cons of drug therapy, adherence, resistance, administration, possible adverse effects & management.
2) If patient committed, begin HAART (generally at least 3 drugs including PI or strong NNRTI). RTC in 1 month.
3) If patient is poor candidate for drug therapy and/or does not want to start therapy, RTC q 3 - 4 months for follow-up.

6

Is adherence for each drug ≥ 85%?

No

Yes

7

Reinforce education, RTC 1 month

8

Verify administration is correctly documented on the computer:
1) Counsel patient regarding importance of adherence.
2) Identify & treat adverse effects.
3) RTC in 1 month.

9

Is adherence for each drug ≥ 85%?

No

Yes

11

When adherence < 85% for 2 consecutive months:
1) Whenever possible, refer patient to clinical pharmacist for adherence counseling and education. Clinical pharmacists will see patients one time only. Do not refer patients that have been seen in the past.
2) Obtain expedited referral for evaluation by Infectious Disease Specialist/Clinic or designated physician (Texas Tech Units) to determine subsequent management and to consider possible discontinuation of therapy (may be done by telemedicine/DMS).
3) If therapy discontinued, may consider restarting therapy after 3 months if patient is more committed to therapy (Begin at box #5).
4) RTC q 3 months, obtain CD4 count & viral load q 3-4 months.

12

Is adherence for each drug ≥ 85%?

No

Yes

13

Verify administration is correctly documented on the computer:
1) Counsel patient regarding importance of adherence.
2) Identify & treat adverse effects.
3) RTC in 1 month.

14

Obtain viral load.

15

Is adherence for each drug ≥ 85%?

No

Yes

16

Has viral load decreased > 10 fold (1 log)?

Yes

No

17

Continue current drug therapy:
1) RTC at least q 3-4 months.
2) Obtain CD4 count & viral load q 3-4 months.
3) Reinforce education at each visit.
4) Goal of therapy is 10 fold (1 log) decrease in viral load at 8 weeks, nondetectable viral load at 4-6 months after starting drug therapy, & increased CD4 count.
5) Refer patient to Infectious Disease Specialist/Clinic or designated physician (Texas Tech Units) to consider change in drug therapy if:
   a) Goal viral load (nondetectable) not achieved within 4-6 months after starting drug therapy.
   b) Re-appearance of viremia after viral load is nondetectable (confirmed by at least 2 tests 4 weeks apart).
   c) Increase in viral load ≥ 3 fold from nadir (confirmed by at least 2 tests 4 weeks apart).
   d) Declining CD4 count (at least 2 tests).
   e) Severe, unusual, or life-threatening adverse effect suspected.

18

Repeat viral load in 1 month

19

Has viral load decreased > 10 fold (1 log)?

Yes

No

20

Continue current drug therapy:
1) Refer patient to Infectious Disease Specialist/Clinic to evaluate patient for poor adherence, intolerance, versus resistance & to consider changing drug therapy.
2) RTC at least q 3-4 months.
3) Obtain CD4 count & viral load q 3-4 months.
4) Reinforce education at each visit.

The pathways do **not** replace sound clinical judgement nor are they intended to strictly apply to all patients